

**Application for National Practitioner Data Bank Electronic Query  
Health Integrity and Protection Data Bank Query  
and  
AADE Clearing House Report**

Fee for this service is \$25.00. Please remit payment with this application.

Return to: Kentucky Board of Dentistry  
10101 Linn Station Road Suite 540  
Louisville, Kentucky 40223

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Suffix: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security #: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Gender: \_\_\_\_

**Employment Information**

Name of Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_ Room/ Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Residential Information**

Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone #: ( \_\_\_\_ ) \_\_\_\_ - \_\_\_\_

**Professional Information**

Licensed Profession: \_\_\_\_\_ Degree Held: \_\_\_\_\_

Federal DEA Number (s): \_\_\_\_\_  
\_\_\_\_\_

Previous/ Present State Licenses:	STATE	LICENSE #
_____	_____	_____
_____	_____	_____
_____	_____	_____

Education:	SCHOOL ATTENDED	YR OF GRADUATION	DEGREE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

*for office use only*

Fee Paid: \_\_\_\_\_

Date Fee Paid: \_\_\_\_\_